

Benrus Surgical

at Barnes Jewish St. Peters

Patient History Dr. Miller Patients

ALL QUESTIONS MUST BE ANSWERED

Name: _____ Age: _____ Date: _____ DOB: _____

What is your primary problem? How long has it been going on? _____

Who is your Primary Care Doctor: _____ Referring Doctor: _____

Please indicate if you have had any of the following:

Rectal pain	Y/N	Constipation	Y/N
Rectal bleeding	Y/N	Diarrhea	Y/N
Itching/Burning	Y/N	Blood in Stool	Y/N
Protrusion/Swelling	Y/N	Change in bowel habits	Y/N
Discharge	Y/N	Fecal Incontinence	Y/N
Abdominal Pain	Y/N	Diverticulosis	Y/N
Nausea	Y/N	Vomiting	Y/N

Have you had a Colonoscopy? _____ When?/Where? _____

How often do you move your bowels? _____

Do you need to take antibiotics before surgical or dental procedures? Why? _____

Have you ever been treated for the following: Chlamydia: Y/N Gonorrhea: Y/N

Syphilis: Y/N Venereal Warts: Y/N Herpes: Y/N HIV/AIDS: Y/N Hepatitis: Y/N

Have you ever received Radiation Therapy or Radiation Seeds for any reason such as prostate cancer or Cervical cancer? Explain? Y/N _____

Current Medications

Allergies (meds, Latex)

Surgical History

Social History: Tobacco Y/N
Alcohol Y/N

Amount? _____
Amount? _____

Review of Systems

General	Weight loss	Y/N
	Sleep Apnea	Y/N
	Dizziness	Y/N
	Light-headed	Y/N
	Weakness	Y/N
Eyes	Vision changes	Y/N
ENT	Hearing changes	Y/N
Cardiac	Chest Pain	Y/N
	Chest pressure	Y/N
	Tightness	Y/N
	Palpitations	Y/N
Respiratory	Shortness of Breath	Y/N
	Coughing	Y/N
	Wheezing	Y/N
Urinary tract	Frequent urination	Y/N
	Burning	Y/N
	Inability to urinate	Y/N
Musculoskeletal	Leg swelling	Y/N
Lymph	Swollen glands	Y/N
Hematologic	Easy bruising	Y/N
Skin	Rashes	Y/N

Medical/Family History:

(Do you or your family have any of the following problems?)

	Patient	Family
Colon Cancer	_____	_____
Colon Polyps	_____	_____
Ulcerative Colitis	_____	_____
Crohns disease	_____	_____
Other cancers	_____	_____
Heart Disease	_____	_____
Hypertension	_____	_____
Diabetes	_____	_____
Stroke	_____	_____
Lung Disease	_____	_____
Liver Disease	_____	_____
Kidney Disease	_____	_____
Blood clotting problems	_____	_____

Physician Signature _____



Name: _____

DOB: _____

Receipt of Notice of Privacy Practices

Initial _____ I acknowledge I have received or I have been provided the opportunity to receive a copy of BJC's Notice of Privacy Practices that explains when, where and why my protected health information may be used or shared by BJC Medical Group.

Patient Communication Preferences

Phone number for voice message(s): _____

Cell number for text message(s): _____

Email address: _____

HIPAA Disclosure Authorizations(s)

Initial _____ I authorize BJC Medical Group to provide the following person(s) with my protected health information:

Print Name: _____ Relationship to Patient/Phone number: _____

Print Name: _____ Relationship to Patient/Phone number: _____

Initial _____ I **do not** authorize BJC Medical Group to:

Disclose my protected health information to anyone other than myself, except as permitted by HIPAA and as described in BJC's Notice of Privacy Practices.

Prescription Authorization

Initial _____ I authorize BJC Medical Group to allow the following person(s) to pick up prescriptions on my behalf:

Print Name: _____ Relationship to Patient: _____

Print Name: _____ Relationship to Patient: _____

I understand the HIPAA Disclosure Authorization(s) above may be revoked in writing at any time; however, the revocation will not affect disclosures of information previously authorized. I understand this authorization is valid while I continue to receive services from any BJC Medical Group provider.

Signature of Patient/Personal Representative

Relationship to Patient

Date